Substance Abuse and Mental Health Services Administration
38th Meeting of the SAMHSA National Advisory Council
Minutes
December 6-7, 2005
Rockville, Maryland

The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Advisory Council convened for its 38th meeting on December 6-7, 2005, at the SAMHSA offices in Rockville, Maryland. The meeting was co-chaired by Charles G. Curie, M.A., A.C.S.W., Administrator, SAMHSA, and Daryl W. Kade, M.A., Executive Director, National Advisory Council, and Associate Administrator for Policy, Planning and Budget, SAMHSA.

Council members present: Gwynneth A. E. Dieter, Faye Annette Gary, Ed.D., R.N., Barbara Huff, Thomas A. Kirk, Jr., Ph.D., Thomas Lewis, Theresa Racicot, Kenneth D. Stark, and Kathleen Sullivan.

Council members absent: James R. Aiona, Jr., Columba Bush, and Diane Holder.

Ex-officio member present: Laurent S. Lehmann, M.D.

Council Executive Secretary: Toian Vaughn, M.S.W.

Non-SAMHSA Federal staff present: 10 individuals (see Tab B for Federal Attendees List).

Representatives of the public present: 33 individuals (see Tab B for Public Attendees List).

TUESDAY, DECEMBER 6, 2005

Welcome and Opening Remarks

SAMHSA Administrator Charles Curie, M.A., A.C.S.W., called the meeting to order at 9:13 a.m. and welcomed attendees. He noted the significant and tragic losses to Gulf Coast victims of the recent hurricane season. He also stated that the hurricanes brought several challenges to the Department of Health and Human Services (HHS) and SAMHSA. Mr. Curie lauded the inspirational service of SAMHSA staff, all of whom contributed to the disaster relief in some capacity. Mr. Curie observed the critical and important role that substance abuse and mental health services played in the overall public health response to this tragedy. Hurricanes Katrina and Rita posed the first major national disaster since the events of September 11, 2001, and although the acute response was accomplished within the first months, the disasters are expected to give rise to more consequences in coming years.

Mr. Curie welcomed back Mr. Thomas Lewis, introduced new member Dr. Faye Annette Gary, introduced other Council members, and noted that Mr. Kenneth Stark now serves as Director of Washington's Mental Health Transformation State Incentive Grant (SIG). Mr. Richard Kopanda serves as Acting Director of the Center for Substance Abuse Prevention (CSAP); former CSAP Director, Ms. Beverly Watts Davis, serves as Senior Advisor for Substance Abuse at SAMHSA,

and Mr. Andrew Knapp is Acting Deputy Administrator of SAMHSA. Former Special Assistant to the Administrator, Stephenie Colston, has become the Director of Alcohol and Drug Abuse for the State of Florida. Mr. Curie introduced Ms. Kana Enomoto, Special Assistant to Mr. Curie; Ms. Cheri Nolan, Senior Policy Advisor for criminal and juvenile justice, and chair of the Criminal/Juvenile Justice Workgroup; and Javaid Kaiser, Ph.D., Director, Office of Applied Studies.

Administrator's Report

Mr. Curie reported that SAMHSA has received an exceptional rating within HHS for its management and programmatic priorities, as reflected on the matrix. The matrix identifies SAMHSA's priorities and management principles and helps to align its focus and resources to operationalize recovery from a public finance and public policy standpoint. Related to expanding substance abuse treatment capacity, in the Access to Recovery (ATR) program, approximately 31,000 people have used vouchers to purchase treatment and recovery support services, while an additional 7,000 persons may also have been supported by the program. To improve services for persons with co-occurring disorders, SAMHSA continues to advance the Blueprint for Change incorporated in the agency's Report to Congress, which also outlines development of the National Co-occurring Center for Excellence. The Treatment Improvement Protocol (TIP) on co-occurring disorders is used in many places around the country. SAMHSA has implemented Co-occurring Disorders SIGs in 15 States, enabling more people with co-occurring disorders to receive screening, assessment, and treatment.

SAMHSA has raised mental health transformation to a priority. *Transforming Mental Health Care in America—Federal Action Agenda: First Steps*, the Federal government's response to the final report of the President's New Freedom Commission on Mental Health, was issued in July 2005. Its 70 action steps lay the groundwork for a transformed system of care that encompasses State and individual delivery systems. To assist States to develop and implement plans for a sustained effort, SAMHSA awarded $19.8 million in mental health transformation SIGs to seven States. In increasing its focus on prevention, SAMHSA has created the Strategic Prevention Framework (SPF), which helps communities identify their unique risk and protective factors for substance abuse and then implement programs best suited to meet their particular needs. A reinvigorated Drug-Free Communities (DFC) Program focuses on coalition building, SPFs, and the National Registry of Effective Programs & Practices (NREPP). DFC's goal is to work with States to assure that every community has access to information and the resources to implement individualized programs, with baselines from which to measure communities' progress in reducing illicit drug and underage alcohol use. SAMHSA is implementing new National Outcome Measures in partnership with State substance abuse and mental health authorities, with full reporting on all measures required by the end of FY 2007. A new Institute of Medicine (IOM) report recommends forging new partnerships with licensing boards and accrediting bodies to help expand the workforce and improve core competencies by providing incentives for educational institutions to improve the science and relevance of the content they teach.

Mr. Curie asked Council members for their input and feedback on potential updates to the matrix that are needed to adapt to the realities in the field. He suggested the prospect of moving disaster readiness and response from a priority to a cross-cutting principle; moving workforce

development to a priority; and adding suicide prevention as a priority. Mr. Curie reasserted that the elimination of seclusion and restraint should remain a priority program that would shift to a cross-cutting principle when non-use of these practices becomes the norm for all age groups in behavioral health care settings, both institutional and community-based. Mr. Curie noted the need to do more to impact underage drinking and asked for guidance on how to reflect this need. He spoke of the importance of consumer and family-driven care, electronic health records, consumer choice in voucher programs, technology for improving information in a family-driven system, and self-directed accounts. Mr. Curie stated that an immediate SAMHSA objective is to intensify our efforts with the Centers for Medicare and Medicaid Services (CMS) to make self-directed accounts possible for persons with mental and/or substance abuse disorders. He also suggested bringing to scale the Screening, Brief Intervention, Referral, and Treatment (SBIRT) program and asserted that more must be done in the areas of criminal and juvenile justice.

Mr. Curie stated that SAMHSA, in acknowledging its joint responsibility with the HHS to improve the human condition throughout the world, has increased its international efforts to build and/or rebuild mental health systems and substance abuse treatment capacity and prevention in post-conflict countries, including Afghanistan and Iraq.

In closing, Mr. Curie observed the need for SAMHSA to focus on its priorities, generate ongoing urgency and excitement in the field, and explain to legislators the need to support SAMHSA's budget requests. He noted that the emphasis in government on the need to curtail spending and make program cuts demonstrates further the importance of setting priorities.

Council Discussion

Dr. Gary observed that the matrix gives clear direction to service providers and academicians. She urged continuing to regard stigma as a cross-cutting principle and urged partnerships with other Federal and State agencies, accrediting bodies, academic institutions, and advocacy organizations. She advocated focusing special attention on populations among which suicide is increasing yearly—African American males, American Indians, and Hispanic youth and adults. Mr. Curie noted that the role of stigma, which is listed along with recovery as a cross-cutting principle, can be further prioritized and highlighted.

Dr. Thomas Kirk described the challenges to State stakeholders in understanding that the ATR, Transformation SIG, and SPF grants represent major system-change initiatives, with the focus changing to a prevention and wellness approach. He also urged emphasizing the link between mental health and primary care services and expressed interest in an update on the Medicare Part D benefit.

Ms. Barbara Huff expressed appreciation for the Transformation SIG's emphasis on a lifespan system change, and urged focus on initiatives related to seclusion and restraint and other high-priority issues, particularly the provision of technical assistance, and that SAMHSA take a similar lifespan approach to ensure adequate focus on children and youth. Ms. Huff noted that seclusion and restraint factor into death and injury at unlicensed residential care facilities, and urged convening a group to consider how stigma relates to young children. Mr. Curie described progress in eliminating seclusion and restraint in adult State psychiatric institutions and other

inpatient settings, achieved with the help of the National Association of State Mental Health Program Directors (NASMHPD). The Child Welfare League and other associations have begun to influence children's settings. Mr. Curie acknowledged the appropriateness of embracing a lifespan approach. He noted that SAMHSA has been working with juvenile justice facilities and suggested a portfolio review to move to the next level.

Ms. Huff urged funding fewer programs, with more resources allocated to evaluate effectiveness. Mr. Curie added that a related issue is bringing to scale programs that demonstrate measurable impact.

Ms. Gwynneth Dieter expressed her belief that the work in Alabama and that of such action groups as the Parent Corps in Colorado to educate, support and unify the community, make a significant contribution to reductions in underage drinking.

Mr. Stark asserted that the term *behavioral health* feeds stigma and negates the physiological/ biological/genetic basis of mental illnesses and drug addictions, and that use of the term also creates difficulty in aligning with the primary care field. Mr. Curie concurred that the term is neither descriptive nor useful. He noted that SAMHSA considers discrimination to be the evidence of stigma, that treatment of co-occurring disorders may be impeded by the term, and asserted that SAMHSA will continue to focus on clarity. Ms. Huff added that young people do not like the term *emotionally disturbed*.

FY 2006 Appropriations Update and HHS "Top 20" Priorities

Ms. Daryl W. Kade, M.A., Executive Director, SAMHSA National Advisory Council, and Associate Administrator, Office of Policy, Planning and Budget, SAMHSA, reported that Congress has not yet passed the FY 2006 HHS appropriations bill. SAMHSA is funded through a continuing resolution that expires on December 17. Passage of an omnibus appropriations bill is anticipated before then, with a budget rescission. SAMHSA has made assumptions about the budget and will adjust funding based on the new law.

Staff are working on the FY 2007 budget. Ms. Kade stated that, to the extent that SAMHSA lacks data to demonstrate programs' effectiveness with systems and individual client outcomes, the agency is at a disadvantage. Strong emphasis is being placed on the data strategy.

Ms. Kade reviewed HHS's top 20 objectives for program and management, the basis for performance assessments. She noted the criticality of scoring well on the management objectives in order to leverage change in the program objectives. Critical objectives that affect SAMHSA include: objective 1(a) —transform the healthcare system - increase access to high quality, effective health care that is predictably safe; objective 2—strategically manage human capital; objective 4—complete the competitive sourcing program; objective 6—improve financial performance; objective 7(a) —secure the homeland – by increasing the capacity of the health care system to respond to public health threats and bioterrorism, as well as natural causes; objective 10(a) —improve budget and performance integration – meet the Office of Management and Budget (OMB) mandated "Green" standards for success; objective 11(b) —improve the human condition around the world – implement a strategy to support emerging democracies with

health diplomacy; objective 15—promote quality, relevance and performance of research and development activities; objective 17(b) —emphasize faith-based and community solutions - expanding faith-based and community partnerships in providing effective health and human services; and objective 19(c) —emphasize healthy living and prevention of disease, illness, and disability—reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.

Council Discussion

In response to a request by Ms. Kathleen Sullivan, Ms. Kade offered to provide public data on SAMHSA's scores on OMB's "Green" Standards for Success, to which the objectives are linked. Ms. Huff asked whether objective 13(b)—increase the percentage of adults and children who have access to quality health care services through private health insurance—includes mental health. Ms. Kade will investigate and she stated that it was developed with CMS in mind, but saw no reason why SAMHSA could not partner with them. Ms. Huff asserted that the objective should include mental health as well as primary care under the CHPs program. Ms. Kade stated that she will convey the message to the agency with the lead for the objective.

Referring to objective 19(a), Mr. Stark noted that *behavioral health* brings to mind diabetes, obesity, asthma, heart disease, cancer, and stroke, along with alcohol, drugs, and mental health. Regarding objective 18, he asked if streamlining might result in moving some SAMHSA functions to HHS. Ms. Kade responded that HHS is likely to centralize the information function and there is some conversation with regard to contracts and grants management. Issues under consideration are performance plans for OPDIVs and STAFFDIVs and ensuring that contracts are sensitive to consumers of centralized functions.

Dr. Kirk asked for guidance on Council members advocating as individuals on issues of importance to SAMHSA. Council Executive Secretary Ms. Toian Vaughn advised that when members attend a Council meeting or represent a U.S. Government agency, they may not advocate as Council members. Under other circumstances, members can discuss with other individuals or organizations issues that have been raised at meetings.

Capitol Hill Update

SAMHSA Director of Legislation, Joseph D. Faha, announced that the Labor/HHS/Education Appropriation had passed the House but was facing objections in the Senate over the Low Income Home Energy Program (LIHEAP) and aid for Katrina. The Senate expects to begin SAMHSA's reauthorization in March 2006. Briefings are to begin in January, at which SAMHSA staff will describe SAMHSA's activities and needs for substance abuse and mental health treatment and prevention services. Related bills focus on underage drinking, mental health transformation, and methamphetamine. Other issues of importance include accountability, workforce development, mental health services for homeless individuals, services for the elderly, and parents relinquishing custody of their children to obtain mental health services. A bill Congress passed outside reauthorization was the National All Schedules Prescription Electronic Reporting Act (NASPER), which gives the HHS Secretary authority for a block grant program for States to establish prescription monitoring; however, no money was

allocated and a duplicate Department of Justice program exists. In response to a request from Ms. Sullivan, Mr. Faha agreed to compile a list of reauthorization issues in which key legislators are interested.

New Mexico Strategic Prevention Framework State Incentive Grant Overview

SAMHSA Senior Advisor on Substance Abuse, Ms. Beverly Watts Davis, explained that SAMHSA's SPF SIGs were designed to create accountability within States, as they implement data-driven decisions that support effective substance abuse prevention planning, as well as flexibility to focus on the highly complex nature of substance abuse. The SPF emphasizes attention to identifying risk and protective factors of children, the nature and scope of the problem, and ways to build service capacity in communities. The implementation phase enlists communities to take the necessary steps to reduce substance abuse and holds States accountable through evaluation measurements of the effectiveness of activities undertaken. The first cohort of SPF grantees included 19 States, later expanded with a realignment of resources to 24 States and two territories. The goal is to provide access for all States to the SPF, which involves helping States convene and coordinate the activities and funding streams of other organizations doing substance abuse prevention, with State advisory councils helping to leverage the funds.

New Mexico Strategic Prevention Framework State Incentive Grant

Mr. Don Maestas, M.S.W., Project Director, New Mexico SPF SIG grant, described New Mexico's Prevention Service System. Partners include State departments, technical assistance organizations, and CSAP/SAMHSA. Mr. Maestas presented examples of people who have turned their lives around through SPF projects and several effective evidence-based programs. The annual $2.3 million, 5-year SIG puts forth evidence-based prevention programs to reduce underage drinking and other substance use and to promote youth abstinence. The program requires rigorous multilevel evaluation.

New Mexico's SPF SIG began in 2004 with a statewide needs assessment and then progressed to building capacity among community-based prevention providers to use data to identify problems and appropriate interventions. The next step was to develop a comprehensive strategic plan, and currently New Mexico is implementing evidence-based programs and activities while also monitoring, evaluating, sustaining, improving, and replacing ineffective activities. Sustainability and cultural competency are overarching elements of the framework.

Mr. Maestas described New Mexico's assessment activities, which include development of indicators to drive identification of intervening or causal factors and support selection of evidence-based strategies, assess substance abuse-related problems, specify baseline data, and identify priorities. Over the past decade, New Mexico has been ranked first or second among States in chronic alcohol mortality and drug-related mortality. Mr. Maestas enumerated the types of data collected, the categories used in analysis, the logic model that guided the analysis, and a number of strategies pursued.

To build capacity, New Mexico has provided problem-focused training programs across the State, and additional training is planned for funding recipients. An RFP was developed for

distribution of services, and eight implementation communities and five capacity communities (communities with high need and low capacity, which will be the focus of intensive capacity-building assistance) have been selected. In March 2006, communities will submit their strategic plans for approval. To conduct the evaluation, a contractor is developing problem statements and the broader prevention framework. Community-level indicators will be measured, and development is underway of tools to measure the effectiveness of environmental strategies. A more difficult task will be counting the number of individuals impacted in communities.

New Mexico's successes include development of the State's third five-year prevention plan, evidence-based prevention programming in more than 40 communities, a strong grants management system, a comprehensive workforce development system, and outcome evaluations that show that evidence-based prevention is measurably effective in reducing teenage alcohol, marijuana, and tobacco use. Mr. Maestas acknowledged the challenges of reducing use still further. He stated that questions remain about whether the right programs are used with the right individuals. He noted that New Mexico has adapted most of the evidence-based programs with their creators to achieve cultural competency to fit its populations.

Council Discussion

Mr. Stark asked whether New Mexico is reviewing archival data sets to identify improvements in school and criminal justice problems. Mr. Maestas responded that they are gathering data on such longer-term effects and that a report is expected to be available within six months.

Ms. Huff asked how New Mexico's SPF SIG interfaces with children's mental health, to which Mr. Maestas responded that collaboration is ongoing with multiple agencies that serve children, including children's mental health.

Dr. Gary commended use of county epidemiological data to plan and implement evidence-based interventions to solve counties' unique problems and noted the importance of health literacy. She asked whether data has been collected for substance use beyond 30 days, whether booster programs are used to sustain transformation, and the extent to which other community-based organizations are involved. Mr. Maestas responded that New Mexico has resources to collect follow-up data at 6 and 12 months, and agreed to share the data with the Council when available. Mr. Maestas stated that some communities conduct booster programs and that SPF may serve as a booster in that it looks at changing community norms among individuals and groups across the lifespan. He noted pride in New Mexico's partnerships with tribal communities to generate and sustain support for continuity, capacity building, and program implementation.

Dr. Kirk observed that New Mexico also has a Transformation SIG, which permits integration of prevention and promotion of mental health to effect systems change. Noting that New Mexico's system is based on asset development, health promotion, and outcome measures, he suggested that the next stage might include system-based outcome measures.

To a question from Dr. Laurent Lehmann on diversity, Mr. Maestas responded that ethnic breakdowns were considered in selecting urban and rural sites for program implementation. Mr. Curie observed that New Mexico has demonstrated the feasibility of implementing a strategy

based on outcomes, has shown that prevention works, and has offered opportunities for messages to bring to scale.

Public Comment

Ms. Cheryl D. Reese, National Association of Lesbian and Gay Addiction Professionals, commended SAMHSA for supporting LGBT issues, particularly production of the 2001 "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals," and urged early publication of the draft training manual. Ms. Reese also noted the impacts of exclusion, stigma, and suicide on alcohol and drug use in the LGBT community, and pointed to emerging increases in youth suicides in the LGBT community. She asked SAMHSA to join in a meaningful partnership.

Ms. Susan Rogers, Mental Health Association of Southeastern Pennsylvania, concurred with Council members on not using the term *behavioral health* and urged using the word *discrimination* whenever stigma is mentioned. Pennsylvania's anti-stigma campaign calls itself an anti-discrimination campaign and does not mention stigma.

SAMHSA's Response to Hurricanes Katrina and Rita

- **Administrator's Remarks**

Mr. Curie amplified his earlier remarks on SAMHSA's response to Hurricanes Katrina and Rita. He stated that he visited the devastated regions of the Gulf Coast on several occasions, paying particular attention to SAMHSA's mental health and substance abuse response.

In Katrina's immediate aftermath, SAMHSA activated the SAMHSA Emergency Response Center (SERC), which supported States and grantees impacted by the storms. SAMHSA provided support to the National Suicide Prevention Lifeline, which experienced a spike in calls of more than 60 percent; held weekly conference calls to coordinate services to consumers; and expanded the Web site to provide information and links to key resources and organizations.

Authorized to make available up to 2.5 percent of its discretionary funding for emergency services, SAMHSA was able to allocate only $600,000 to Louisiana, Mississippi, Florida, and Texas because it was the end of the fiscal year. Funds were disbursed in response to States' assessments of their needs with specific focus on continuity of care, children with serious emotional disturbances, and individuals with addictions who needed treatment. Working with FEMA, SAMHSA made recommendations to award 29 full and 2 partial grants to States for immediate services, for a total of $20.5 million. The SERC coordinated mobilization of more than 300 field workers on mental health and substance abuse issues. Thirty States are eligible to apply for regular services program grants, which provide funds for up to nine months after disaster declarations. SAMHSA will continue to work with States to ensure that mental health assessment and crisis counseling are readily available to residents and evacuees and to establish a longer-term plan to address post-traumatic stress disorders (PTSD), particularly for first responders and vulnerable populations. SAMHSA also will continue its work with Federal partners to help people with chronic disorders. Mr. Curie expressed pride in SAMHSA's staff,

who worked long days and weekends throughout the first several months of the disaster. Nearly half the staff were either deployed to affected areas, or worked in the SERC, while others filled in to continue the usual work.

- **Key Elements of SAMHSA's Response to Hurricanes Katrina and Rita**

SAMHSA Emergency Coordinator Dan Dodgen, Ph.D., presented an overview of the National Response Plan (NRP) that governs the activities of all Federal departments and agencies, including the American Red Cross, in emergencies. The plan, invoked when States request assistance, provides for an Interagency Incident Management Group (IIMG) that sets policy for disaster responses. Recognizing the importance of mental health and substance abuse issues in the aftermath of Katrina and Rita, the HHS requested that SAMHSA be allowed an additional representative seat on the IIMG. The NRP provides for 15 emergency support functions (ESF), of which the most critical to SAMHSA include: ESF6—mass care housing and human services; ESF8—public health and mental health services (led by HHS); ESF14—long-term community recovery and mitigation; and ESF15—external affairs, where SAMHSA provides consultation in public education and information.

Dr. Dodgen reviewed SAMHSA's interactions with FEMA, including the mission assignment process, among whose key components are "deconflicting" (information sharing across systems) and the Crisis Counseling Program. CMHS's 30-year history of emergency response work has established SAMHSA's credibility to lead mission assignments. SAMHSA meets with its ESF8 partners to deconflict information in order to provide the best response to States. SAMHSA maintained communications with Federal and State agencies, nongovernmental organizations, and other stakeholders. Existing partnerships fostered SAMHSA's impact in addressing local concerns with States. In addition, SAMHSA took the lead in working with the Occupational Safety and Health Administration (OSHA) to develop strategies that support people in the field and those who have experienced trauma.

SAMHSA assists local communities to respond to emergency situations; coordinate resources, assets, and activities; provide subject matter experts; provide planning grants; and facilitate getting services on the ground. In response to a question from Mr. Stark about SAMHSA's plans in the case of decimated State infrastructure, Dr. Dodgen stated that extensive planning was essential for SAMHSA to be able to respond as it did, but that the scale and impact of the disaster were unanticipated. He asserted that States performed above and beyond expectations.

- **What is the SERC and What Did It Do?**

Ms. Brenda Bruun, CMHS, Program Analyst, Division of Prevention, Traumatic Stress and Special Programs and SAMHSA SERC Coordinator for Hurricanes Katrina and Rita, stated that the SERC coordinates with other partners and agencies, including the Centers for Disease Control and Prevention, Red Cross, National Association of State Mental Health Program Directors (NASMHPD), National Association of State Alcohol/Drug Abuse Directors (NASADAD), and major mental health guilds, to deliver mental health and substance abuse services after a disaster to support State and local efforts. She explained that immediately after Katrina struck, Mr. Curie activated the SERC, which mobilized all resources in a streamlined

management structure. Through the Incident Command System (ICS), a standardized structure was implemented to eliminate duplication of effort, coordinate communications, and clarify lines of authority and command. The ICS helps to mobilize all resources quickly—personnel, logistics, planning, finance, public information, recording, and communication. Each function is staffed by trained persons who report to the incident commander.

Incident command functions, as described by Ms. Bruun, included triage and assigning tasks; coordinating with emergency coordinators outside the agency; preparing a plan of the disaster's impact to project allocating resources; managing logistics, made difficult because of a lack of housing and transportation and the need to provide nontraditional supplies to protect SAMHSA staff; tracking financial activities; providing accurate public information; and deploying, briefing, and providing support to field personnel. Ms. Bruun stated that she considered the key to a successful ICS to be well-trained staff empowered to make decisions.

SAMHSA provided many staff on a continuous cycle for affected locals and conducted a survey to learn about destroyed facilities in order to assess needs and target resources; the data was posted on the SAMHSA Web site. To Mr. Stark's question about whether funds were used to support local clinicians, Ms. Bruun responded that hiring local displaced clinicians was a priority that was accommodated when possible.

Ms. Bruun provided data concerning clinical sessions, counseling sessions, and referrals to mental health and substance abuse services. Service use is expected to rise at this point after the disaster. Sixty-nine percent of referrals were for additional services such as housing assistance. Many interns staffed the database function, which offered an incomparable professional experience, especially to interns deployed to the field.

Council Discussion

Dr. Gary asked whether focus was given to health professionals and first responders who might experience PTSD, the identity of other stakeholders with which SAMHSA is partnering, whether literacy level and cultural world views are considered when materials are prepared for diverse target audiences, how stigma affects people's choice to accept or reject help, and who were the recipients of the grants awarded. She also requested information on requirements and restrictions related to outcome data and accountability for emergency response grants; asked that the lessons learned document to be developed, which has implications for professional training, be shared with Council members; and suggested that SAMHSA open a discussion of poverty as a risk factor for mental illnesses and substance abuse.

Dr. Dodgen responded to the question about worker care by pointing out how SAMHSA supported its own workers and modeled that behavior. A system of orientation and debriefing was established to prepare people in the field and to permit them to talk about their experiences. A brochure was disseminated on stress and its management to staff in the field. SAMHSA is working with the Occupational Safety and Health Administration (OSHA) on a model for all deployed workers and federalized civilians. Under SAMHSA's guidance, OSHA is preparing materials for family members and workers to help facilitate reentry into the workforce. Ms. Bruun added that contractors involved in the response were required to take the same care as

did SAMHSA staff. In addition, SAMHSA provided services to give local providers a break to go home or to listen to them.

Dr. Dodgen noted that SAMHSA's stakeholder partners include its ESF8 partners, SAMHSA's traditional partners in the mental health and substance abuse fields, and some new partners, including the Administration on Children and Families and the Department of Education, among others. The public information office has worked to develop materials that are linguistically and culturally appropriate for various audiences, including parents, children, teachers, and others.

Dr. Dodgen acknowledged that the issue of stigma is multilayered, but that SAMHSA has broken new ground in terms of recognition at the State and local levels of the importance of substance abuse and mental health in emergency response. He stated that SAMHSA plans to prepare an integrated lessons learned document whose executive summary might be useful to the Council.

Ms. Huff asked how Ms. Bruun and Dr. Dodgen took care of themselves. Ms. Bruun acknowledged that self-care is a difficult thing to model, but that her years of disaster relief experience, eating healthy food, drinking a lot of water, continuing to exercise, and sleeping well helped, along with support from colleagues, friends, and family. Dr. Dodgen echoed her remarks and emphasized friends, family, and faith, along with debriefing with trusted friends and colleagues.

Experiences of Deployed SAMHSA Staff

Three SAMHSA staff members described their experiences in the field: Ms. Rachel Kaul, L.C.S.W., C.T.S., Public Health Advisor, Division of Prevention, Traumatic Stress, and Special Populations, CMHS; Mr. Kevin Chapman, D.M., Project Officer, Drug Free Communities, CSAP; and Ms. Anne M. Herron, M.S., C.R.C., CASAC, Director, Division of State and Community Assistance, Center for Substance Abuse Treatment, CSAT.

Ms. Kaul explained that when a presidentially declared disaster occurs, she contacts the State disaster mental health/substance abuse coordinator, reviews the application process for the Crisis Counseling Program (CCP), and provides technical assistance. States have just 14 days from the time of declaration to apply for CCP funding. Ms. Kaul and two colleagues traveled to the affected States to assist in the assessment of how they would amass and apply resources. She described Mississippi's disrupted mental health infrastructure and the vast magnitude of need evident in the affected areas. Staff's ability to apply regulations creatively to fill gaps in financial, human, and other resources was critical. For example, the magnitude of the problems warranted the unusual step of enlisting consultants to help States write grant applications to expedite funds for services. The CCP, which will provide services in the affected areas for about a year, relies on existing strengths to help communities find or create resources and hires and trains indigenous professionals and paraprofessionals to assess needs and solve problems.

Ms. Kaul distributed copies of SAMHSA's "A Guide to Managing Stress in Crisis Response Personnel," designed to help States increase their focus on first responders and nontraditional responders. She highlighted the importance of SAMHSA staff as a supportive, listening presence, able also to help solve problems with community resources and to help think in

nontraditional ways. She found mental health and substance abuse consumers in community centers frequently to be among the first people to respond, and they did so creatively and effectively. She asserted that SAMHSA can help States learn to use consumers as a resource.

Mr. Chapman described his experiences on a relief team in Houston that consulted on providing professional mental health services to responders and evacuees, and helping Harris County with long-term planning. Historically a minister specializing in pastoral counseling, Mr. Chapman said he engaged his clinical and spiritual background in the consultative and assessment process and used his organizational skills to assist the group. He recognized that the alcohol/drug community was not involved in the county planning meetings and drew in the Council on Alcohol and Drugs to participate. He also served as liaison to the SAMHSA SERC.

Mr. Chapman recounted his feelings in the stressful time that Houston evacuated the evacuees from elsewhere on the Gulf Coast in the face of approaching Hurricane Rita. Once the evacuees had departed, his team drove to San Antonio. He experienced a reaction to the stress; the team discussed options, and Mr. Chapman was offered the opportunity to return home. Physically exhausted and mentally fatigued, he realized he had taught persons for years about the necessity to take care of themselves in order to help others. He asked to come home, feeling guilty about leaving his teammates behind, not completing his 14-day deployment, and being afraid.

Ms. Herron explained that in her work with single State authorities for substance abuse, she has responsibility for issues, such as co-occurring disorders, homelessness, and prisons, which emerge with hurricane experiences. Two weeks after Hurricane Katrina hit, Louisiana's mental health authorities requested SAMHSA's consultative assistance on command and control function; provide support, care, and debriefing services to a stressed executive team; ensure that the work of the State mental health office for first responders was appropriate, sustainable, and the right thing to do; and review needs of the system-of-care for the next three to five years. Ms. Herron stated that she traveled to Louisiana with a command and control expert to review organizational structure, issues the State had dealt with, and anticipated events and activities. And while they engaged executive staff to gauge the department's values, priorities, functions, initiatives, and relationships, they made time to allow staff to talk about the affect of their experiences. Ms. Herron presented recommendations that were adopted by the department regarding long-term planning, media response, and staff functions from an integrated mental health, substance abuse, and developmental disabilities perspective. This request for similar assistance was repeated by Louisiana's Secretary of Addictive Disorders, which SAMHSA provided.

Ms. Herron observed that a great number of State agency staff were impacted significantly by the hurricanes, to an extent not seen even following September 11. She considered as an accomplishment providing brief administrative respite to the staff.

Council Discussion

Mr. Stark asked whether the 14-day deadline for the CCP application survived the hurricane experience. Ms. Kaul responded that the deadline remains intact and that the immediate deadline helps States to place a high priority on securing short-term support in times of crisis.

Dr. Gary offered suggestions for novel, nontraditional partners with whom to work in response to crises, including beauticians, storefront and other ministers, historically Black institutions, sororities, fraternities, Masonic Lodge members, and similar organizations that are relevant to Hispanic and disenfranchised Caucasian populations. Ms. Kaul mentioned other nontraditional partners, including postal workers, bartenders, waiters and waitresses, and flight attendants. She noted that significant partnerships were established quickly with faith-based groups and groups that focus on rebuilding and conduct outreach community case management, and that these kinds of linkages are expected as part of the CCP application.

To a question from Ms. Sullivan, Ms. Herron responded that the deployed SAMHSA staff had no awareness of animosity between the Federal and State governments. Ms. Kaul noted that people expressed frustration with the bureaucracy, but the focus always was on moving to the next step.

Dr. Kirk asked about lessons learned regarding the dramatic modification of SAMHSA's operations during the emergency response. Ms. Herron responded that the limited duration of staff deployments protected them from wanting to do too much. The limit also enabled remaining staff to know that they would need to do extra work for only a short period of time. Mr. Curie added that SAMHSA played a major role in helping its people shift their role and mission to focus on the emergency response, and that SAMHSA staff gained support and energy from caring about each other. He noted the importance of cultivating an attitude and a culture that celebrate accomplishments, news, and progress in daily briefings.

Dr. Kirk asked whether formal debriefings were part of the September 11 experience. Ms. Herron responded that everyone in the field had routine debriefings and then follow-ups upon return from deployment. Ms. Kaul noted that the SERC established a buddy procedure to foster every-day communication. Ms. Bruun described efforts to support staff and other people in the field. She observed the receptivity of leadership to flexibility in giving people time off, purchasing unorthodox supplies, and creating a safe environment to acknowledge feelings and the need for help and to solve problems. Ms. Kaul stated that the SERC worked with best practices, using extensive research on deployment to the field. Dr. Kirk observed that between the organization's culture of care and staff's personal and professional experience, SAMHSA has been strengthened. Ms. Theresa Racicot and Ms. Dieter acknowledged panel members' willingness to talk about their feelings, which they expected to contribute to more healthy responses by others.

Dr. Lehmann expressed appreciation for the work SAMHSA staff accomplished. Ms. Huff noted the importance of acknowledging the challenges of re-entry into routine after crises, an issue for individuals and organizations engaged in support of families in which a member has mental health problems. Mr. Curie acknowledged that SAMHSA has been changed, although it is not yet clear in what ways.

Consideration of the June 27, 2005, SAMHSA Council Meeting Minutes

Council members unanimously approved the minutes of the meeting held on June 27, 2005.

Public Comment

Ms. Marian Schineholts, American Occupational Therapy Association, reported that occupational therapists were refused by the Red Cross when they tried to volunteer their services. She noted that practitioners work with people with serious mental illnesses and with older people with mental health and substance abuse problems. She observed that their services are likely to be helpful in the extended recovery effort to rebuild communities.

Dr. Mary Knipmeyer, MCK Consultants, who conducts grief counseling for the loss of companion animals, noted that some people refused to leave their homes because they could not take their pets to shelters. She expressed hope that the mental health aspect of how people relate to companion animals and their role in terms of survival are better understood.

Ms. Susan Rogers, Mental Health Association of Southeastern Pennsylvania, asked about actions people with mental illnesses can take in disaster response situations. Ms. Kaul responded that once people are safe, people with mental illnesses in community outpatient situations and people experiencing substance abuse disorders often are valuable resources in the disaster response.

Matrix Update

Mr. Curie invited additional feedback from Council members on updates to the matrix discussed earlier in the day. Ms. Sullivan suggested broadening SAMHSA's *disaster* response to a *crisis* response approach in order to include assistance in military base closings, unemployment, and major plant closings. She suggested adding crisis response to the matrix as a cross-cutting principle. Ms. Dieter advocated for adding suicide prevention to the matrix.

Dr. Gary suggested devising a way to highlight the redwoods on the matrix. Mr. Curie identified the "big redwoods"—substance abuse treatment capacity expansion, co-occurring disorders, mental health systems transformation, and SPF—as systemic priorities that help set priorities for the budget process. He entertained suggestions from the Council on making further distinctions or on bringing others into the major redwood area. He expressed hope that co-occurring disorders within a few years will no longer be a major redwood. Dr. Gary suggested that SAMHSA communicate visually to the States a sense of urgency to transform their systems accounting to make possible widespread implementation of appropriate screening, assessment, and treatment modalities for co-occurring disorders.

Dr. Gary advocated for integrating stigma—a major barrier to seeking mental health care—and alleviation of poverty into the matrix.

To a question from Ms. Huff, Mr. Curie responded that HIV/hepatitis is a priority because intravenous drug use is a major cause of the spread of HIV; mental health needs of persons with or at risk for HIV is an important issue; and SAMHSA must be part of the public health response to prevent HIV. Dr. Gary added that young adults and adolescents use alcohol and substances to prepare themselves to participate in unsafe sex.

Adjournment

The meeting adjourned at 5:10 p.m. and reconvened the following day at 9:00 a.m.

WEDNESDAY, DECEMBER 7, 2005

Opening Remarks

Ms. Kade welcomed Council members to the continuation of the Council meeting.

Medicaid Modernization Act

SAMHSA Medical Advisor Anita Everett, M.D., explained aspects of the new Medicare prescription drug benefit. Fourteen percent of the 42 million Medicare recipients are disabled. About 7 million are dually eligible for both Medicare and Medicaid benefits, many in association with a mental illness and some because of substance abuse. As of January 1, 2006, these individuals no longer will receive medications through Medicaid and must switch to Medicare. SAMHSA has been working closely with CMS on effecting the transition.

Distinct from Medicare individuals who meet State requirements for Medicaid eligibility, low-income individuals who earn 150 percent of the federal poverty level or less will benefit from this change. This low-income group will pay no premiums and have limited co-payments.

Because of concern that certain populations may be impacted highly by the benefit itself—which encourages competition among companies and making arrangements for individual prescription drug plans—CMS created six special categories that provide extra access to certain medications. Three of the six categories include medications often needed by persons with mental illnesses—antidepressants, antipsychotics, and convulsants. All the medications in these categories must be covered by each of the insurance plans.

SAMHSA has undertaken a wide variety of education and outreach activities to explain the benefit, including, among others, contacts with the public, State leads for the benefit, and substance abuse groups; Web site links to relevant pages; partnership grants to several advocacy organizations; and a *SAMHSA News* issue dedicated to the benefit.

Council Discussion

Dr. Kirk expressed concern about changing formularies that may require dual eligibles to change medications involuntarily. Dr. Everett responded that CMS has been sensitive to the need to keep antipsychotic, antidepressant, and anticonvulsive medications on the formulary. CMS has established safeguards against people having to change, plus an appeals process to place a medication on the formulary, and another appeals process for the co-pay level of a medication. Dr. Kirk pointed out that the co-pay for multiple medications can represent a significant cost for some individuals. Dr. Everett stated that the Federal government and pharmaceutical companies cannot waive the co-pay because of kickback laws, but pharmacies can agree not to bill at the

point of sale, and charities can cover the cost of co-pays. Some companies have expressed interest in creating opportunities to offset co-pays. Dr. Kirk stated that Connecticut has appropriated $5 million for 1-year to help with co-pays and expressed concern that the legislature may decide in the future no longer to do so. He asked whether it would be possible to extend the enrol1ment date, and Dr. Everett responded in the negative.

Dr. Gary asked about possible policy and patient-care effects of the National Institutes of Mental Health's (NIMH) Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study of the efficacy of atypical antipsychotics. Dr. Everett stated that the study might prompt reconsideration of the older antipsychotics as feasible, legitimate treatment, but noted that only preliminary data have been published. CMS has defended against changes to the medications access rules, but Dr. Everett acknowledged that vigilance among advocacy communities may help preserve the benefit without the need for "fail-first" policies. Dr. Gary urged devising a mechanism to track the potential for fail first. Dr. Everett agreed to provide information on tracking mechanisms.

Ms. Sullivan identified the need for simple, State-specific brochures about the benefit. She observed that people who are indigent or illiterate may have least access to explanations. Dr. Everett noted that dual eligibles have been enrolled automatically, with an option to change plans. Ms. Sullivan responded that it is unclear how to change plans and how to get help to do so. Council members suggested a conference call to discuss the issue. Dr. Kirk noted that his State recognizes the importance of case managers who understand the benefit. He noted NASMHPD's efforts on the issue and urged tracking. Mr. Stark urged tracking both eligibility and access. Dr. Everett stated that she will provide information on tracking individuals' transition to the new plan and will investigate and report on individuals' experience with any influence by insurance plan gatekeepers to change psychotropic drugs in response to findings of effectiveness studies.

Ms. Dieter supported the strategy of devising short synopses of the benefit for broad dissemination, but noted that tracking the issue is likely to be costly. Dr. Everett reiterated that dual eligibles already are enrolled and should be able to access their medications. Ms. Huff suggested the Federation of Families for Children's Mental Health and other organizations as partners in providing information. Dr. Gary suggested also tracking quality of treatment, for example, by systematic assessment of movement disorders. Ms. Kade stated that she will report to Mr. Curie on the discussion, with an eye to convening a SAMHSA Council conference call together with CMS representatives, on the issue prior to the June Council meeting.

Preventing Underage Drinking

Ms. Kade stated that SAMHSA plans to focus additional attention on prevention of underage drinking. Secretary Leavitt convened the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), and Surgeon General Richard Carmona has announced his intention to launch a call to action on the prevention of underage drinking. Expert teams from most States and many territories attended an October 31, 2005, ICCPUD meeting.

Data show declines in teen drug and tobacco use, but underage drinking remains a problem. Alcohol is the most widely used substance of abuse among America's youth, and underage

drinking is the leading public health problem in the United States. Measurable targets are to be set for reducing prevalence of underage alcohol use, reducing binge alcohol use, and increasing age of first use. Underage drinking has been accepted as a right of passage, but it is time to change the culture from acceptance to abstinence, and for parents talking to their children early and often.

- **SAMHSA's Underage Drinking Prevention Effort**

SAMHSA Associate Administrator for Alcohol Prevention, Mr. Stephen Wing, enumerated SAMHSA's main activities in reducing underage drinking: ICCPUD, a standing committee to coordinate federal activities; SPF SIGs, with emphasis on underage drinking; Reach Out Now, a collaboration between SAMHSA and *Scholastic Magazine,* which provides underage drinking prevention materials for all U.S. fifth and sixth graders and their parents; community teach-ins (www.teachin.samhsa.gov); town hall meetings to raise awareness of evidence on consequences of underage drinking and to foster creation of local coalitions; Web site on underage drinking (www.stopalcoholabuse.gov); report to Congress on underage drinking; and Ad Council PSAs.

- **Underage Drinking Prevention Advertising Campaign**

Alvera Stern, Ed.D., SAMHSA Office of Communication Team Leader, described the Ad Council Underage Drinking Prevention Program, including a research review that revealed, for example, that about 29 percent of underage people ages 12 to 20 reported monthly alcohol use. Of underage people, 40 percent were ages 12 to 17. The death rate among underage youth caused by alcohol is 6.5 times more than deaths from all other illegal drugs combined. Young people who drink before age 15 are more than five times more likely to develop alcohol problems than those who start after age 21. Among alcohol-dependent adults in treatment, about 95 percent say they had their first drink before age 21. Studies show that protective factors from parents are significant. Young people are less likely to drink if their parents are bonded with them, talk with them, enforce neither very rigid nor loose rules, and set boundaries that change as they mature. Parents underestimate their influence and have difficulties in knowing what to say. The campaign's objective is to encourage parents to speak with their children early and often to delay onset and reduce underage drinking.

Focus groups found that most parents thought drug use and sexual activity to be more critical than underage drinking, and thought other kids were drinking, but not theirs. Although parents display denial, they are concerned about such safety issues as drunk driving. The statistic that drinking before age 15 linked to alcohol dependence after age 21 resonated with parents. The Ad Council PSAs' target audience is parents of children ages 11 to 15. The key message is that the chances of young persons developing a problem increase the younger they start drinking. The action message is to talk with kids before they start drinking. Dr. Stern showed several PSAs, which include TV, radio, and print ads. The materials will be made available along with training of prevention workers in the regions of planned town meetings to enlist media in running the PSAs. The campaign also will ensure that *Scholastic Magazine* handouts highlight the work and resources of www.stopalcoholabuse.gov.

Council Discussion

To questions from Ms. Racicot, Dr. Stern responded that SAMHSA is not buying air time, but that the Office of National Drug Control Policy (ONDCP) acceptance of the campaign will ensure greater play time. The campaign has been mounted with consultation of the alcoholic beverage industry and advocates. Mr. Wing noted that the campaign reflects IOM recommendations to target parents. Mr. Stark stated that it is good that alcohol is on the federal agenda, but *not* good that the government has not bought time for the ads. Ms. Dieter concurred with Mr. Stark's assessment.

Ms. Sullivan commented on a *New York Times* report that alcohol companies target young drinkers with promotions. Dr. Kirk stated that Connecticut works with community and State colleges in Connecticut to reduce binge drinking. Ms. Racicot noted that beer companies post video games on their Web sites, an advertising ploy about which most parents are unaware. She pointed to the paradox of vociferous protests of lead in paint and water, and laws requiring infant seat use, yet alcohol represents the worst poison in kids' lives—a legal substance supported by a powerful lobby. She noted the need to urge parents to talk about their children's alcohol problems to empower other parents to talk about their own families' similar issues. She anticipated that the Surgeon General's call for action will carry power.

Ms. Sullivan noted that alcohol ads appear on cable networks and asked about related research. Mr. Wing responded that studies are ongoing, but that a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) study has found inconclusive evidence on the influence of broadcast alcohol messages on drinking behaviors. Ms. Dieter supported Ms. Racicot's remarks and concurred with the need for appropriated funds to purchase air time for prevention ads. Ms. Huff related her family's personal story about alcohol and drug abuse and the importance of knowing how to talk to young children about alcohol use.

Dr. Gary suggested the need for evaluation of the impacts of teach-ins and the Reach Out program. Mr. Wing reported that *Scholastic Magazine*'s evaluation shows that materials are well received, but not as well received as SAMHSA would like. One challenge is to ensure wider usage. Ms. Dieter suggested the need for reinforcement of prevention programs in middle school and then high school. Council members expressed praise for the PSAs.

National Child Traumatic Stress Initiative Programs

- **Overview**

SAMHSA Senior Advisor on Children, Ms. Sybil Goldman, described effective community programs related to the National Child Traumatic Stress Initiative. The National Child Trauma Stress Network develops effective approaches for treating people exposed to trauma by providing training and direct services in communities. The $25 million congressional initiative incorporates the National Resource Center, a collaboration by UCLA and Duke University; treatment and service adaptation sites (category II); and community service sites (category III). The initiative covers all aspects of trauma, including improving access and quality of treatment.

The National Resource Center involves families at all levels to provide leadership, develop and maintain the network structure, provide technical assistance, and coordinate education and training. Category II sites develop, implement, and disseminate effective programs, and play a role in training, developing products, adapting trauma interventions in special populations and settings. Category III sites provide services in various child-serving systems in communities and conduct evaluations of interventions in various communities.

- **Kennedy Krieger Institute Family Center (KKFC), Baltimore, Maryland**

Dr. Elizabeth Thompson, Ph.D., Director of Division of Clinical Services, KKFC, explained that the center traditionally worked with children with developmental disabilities in foster care, but has expanded to offer programs for children and families impacted by violence. KKFC serves 1,000 children annually in clinic, home, and school settings in high crime areas. About 91 percent of the children have experienced at least 1 of 45 types of traumatic events, and the average child has experienced three traumas.

After receiving SAMHSA funding in 2003, the Center joined the trauma network. Participation involves submitting data to a common data pool and forming links with childhood trauma experts. KKFC runs a clinic that provides trauma-focused mental health treatment adapted for children who are deaf or hard of hearing. KKFC's involvement with the network also has led to full engagement of families and service providers as partners in program development and service delivery, staff improvement, adoption and adaptation of best practices, evidence-based treatment practices, training, and effective implementation. KKFC has focused on its staff participating in a training program to conduct and embed trauma-focused cognitive behavioral therapy systemically in communities. To serve as a change agent, KKFC has trained about 800 people in communities to work more effectively with traumatized children and families in their respective service sectors. The community advisory board includes caregivers and people who have received treatment.

Lessons learned from KKFC's work with relocated Hurricane Katrina evacuees—teenagers who had been traumatized by the experience—include: (1) trauma changes you forever, despite healing and recovery, and (2) mental health professionals should never lose sight of the hope and resiliency that families bring when they come for treatment.

- **DePelchin Children's Center (DCC), Houston, Texas**

Mr. Robert Hartman, M.S.W., Executive Vice President and Chief Operating Officer, DCC, described services provided by DePelchin Children's Center, including early intervention and mental health treatment and services for homeless mothers. The center serves 27,000 children and families annually; about 5,000 children have experienced multiple, complex traumatic incidents. The SAMHSA grant became a catalyst for transformative change for his organization, whose goals include increasing accessibility, developing a community network of professionals, improving outcomes for children in child welfare and mental health services, and translating research into the organization's practice. Mr. Hartman highlighted major accomplishments, including establishing an internal core trauma team to change the culture to a learning organization. A community trauma network involving more than 200 Houston organizations

conducts training and disseminates materials, and network counselors are accessible on the Web site to increase access.

As part of the network, DePelchin has participated in workgroups on foster care, data, public policy, school intervention, system integration, residential, and training. Information sharing is a highlight, particularly on financing for a child welfare service, monitoring psychotropic drugs in the child welfare system, workforce issues in implementing trauma care, and establishing community services around trauma services. Network training has included trauma-focused cognitive behavioral therapy, parent/child interactive therapy, and the Sanctuary model for residential care. Statistics conclusively demonstrate the value of that model, including reduced length of stay by 50 percent—lower than the State average—and an 89 percent reduction in seclusion and restraint for disruptive behavior. He acknowledged that the changes are linked directly to participation in the network.

In addition to continuing care for 400 children in foster care and more than 50 children in residential centers, DePelchin coordinated mental health services following Hurricane Katrina to children of the 30,000 evacuee families in the Astrodome and convention center. Texas and Houston have arranged for DePelchin to provide a variety of services related to disaster response, and the organization coordinates with the national network in distributing materials to foster that process. Mr. Hartman showed a PSA developed for the disaster response. To help field media questions, the national center provided points of discussion, and DePelchin has fielded 1,600 telephone calls per month as a result of the PSAs.

Council Discussion

In response to Ms. Huff's question about how to eliminate remaining seclusion and restraint from DePelchin's work, Mr. Hartman explained that the reduction was achieved by a focused effort to review and track every restraint on multiple dimensions. Weekly training meetings centered on alternative ways to talk to kids that involve prevention and anticipation, helping staff recognize their own emotions, and requiring staff to facilitate turning to each other if one is "hooked" by a child's behavior. Each child and staff member debriefs for each episode. Staff are told that property damage is acceptable, but not retraumatization of a child. Some restraints are protective, to prevent harm to self or others. DePelchin is looking at its case plans and working with a mental hospital for partnership and mutual respite care. Therapy has shifted from therapists to youth care workers who develop relationships with the children. Ms. Huff suggested the need to disseminate this kind of information. Ms. Goldman observed that the centers and providers that have made this conversion are the best trainers of others. Noting that seclusion and restraint is a major type of trauma, she suggested that this training may be conducted through the national network.

Dr. Gary suggested the need to move the discussion beyond network participants to facilitate learning by nonmember organizations. She also asked how DePelchin assists staff to handle their own trauma, anxieties, fears, and frustrations about aggression. Mr. Hartman responded that child welfare organizations provide training on these issues. In addition, DePelchin has changed the hiring interview process; applicants talk about their own experiences and how they respond to people getting angry or using provocative language. The topic is discussed at staff

meetings, and debriefing sessions nurture culture change among veteran staff. Dr. Thompson stated that KKFC has a secondary trauma support group for staff, and awareness of diverse cultural perspectives is an important topic for staff discussion. Ms. Goldman noted that Dr. Marlene Wang at the National Center talks about compassion fatigue and the work necessary with caregivers and providers.

Race Against Drugs

Mr. Ron Steger explained that Race Against Drugs engages young people's interest in motor sports to convey an anti-drug message. Race Against Drugs has disseminated 450,000 activity books on behalf of SAMHSA to Texas, Alabama, and Mississippi. NASCAR drivers Richard Pettit, Daryl Waltrip, Bobby Hamilton, Jr., Ricky Rudd, and the Andretti family are spokespersons, and the program is in discussion with Dana Patrick. Race Against Drugs partners with 24 sanctioning organizations, including IndyCar, NHRA, and Grand Prix.

Public Comment

Dan Fisher, M.D., Executive Director, National Empowerment Center, reported that SAMHSA-supported work in Louisiana includes peer support training for consumers to provide training to others. His organization worked with Louisiana's mental health commissioner to include peer support in emergency training in the FEMA grant. Peer support and peer counseling, highly developed practices used with beneficial effect after Oklahoma City and September 11, have promoted establishment of consumer-run organizations and peer support capability. Other States are using the new information to establish crisis planning that engages consumers as peer counselors. In some parts of the country, consumers are providing trauma-informed peer support similar to the themes discussed in the previous panel.

Ms. Susan Rogers, Mental Health Association of Southeastern Pennsylvania, noted that Pennsylvania is working toward a policy of zero seclusion and restraint.

Ms. Thelma King Thiel, Chief Executive Officer, Hepatitis Foundation International, stated that her organization has trained CSAP and CSAT grantees as well as counselors in Florida.

Ms. Carolyn Stuart, Consumer National Technical Assistance Center (CONTAC), West Virginia, urged cultural awareness in planning by the Race Against Drugs to ensure that the message reaches large segments of the population.

Closing Remarks

Ms. Kade recapped highlights of the meeting and commitments to provide Council members with additional information.

Adjournment

The meeting adjourned at 12:06 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

_____	_____
Date	Daryl Kade Executive Director, SAMHSA National Advisory Council, and Associate Administrator for Policy, Planning and Budget, SAMHSA

Attachments:
Tab A – Roster of Members
Tab B – Attendees